Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Edarbi® & Edarbyclor® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____
ICD-10 Code(s): _____

Select if the patient has tried and failed therapy with any of the following for 30 days:

- ❑ Amlodipine valsartan
- ❑ Amlodipine valsartan HCTZ
- ❑ Candesartan
- ❑ Candesartan HCTZ
- ❑ Eprosartan
- ❑ Irbesartan
- ❑ Irbesartan HCTZ
- ❑ Losartan
- ❑ Losartan HCTZ
- ❑ Telmisartan
- ❑ Telmisartan amlodipine
- ❑ Telmisartan HCTZ
- ❑ Valsartan
- ❑ Valsartan HCTZ

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.